SENATE BILL NO. 434

INTRODUCED BY LEWIS

A BILL FOR AN ACT ENTITLED: "AN ACT REVISING THE FORM FILING AND APPROVAL PROVISIONS OF THE INSURANCE CODE; PROVIDING REQUIREMENTS FOR CERTIFICATION AND DELIVERY; ALLOWING A FORM THAT IS NOT DISAPPROVED BY THE COMMISSIONER OF INSURANCE WITHIN 60 DAYS TO BE CONSIDERED APPROVED; PROVIDING REQUIREMENTS FOR INSURERS REGARDING NOTIFICATION OF FORM USE; PROVIDING REQUIREMENTS FOR THE COMMISSIONER REGARDING DISAPPROVALS OR WITHDRAWALS OF APPROVAL; PROVIDING THAT THE FORM FILING AND APPROVAL PROCESS FOR HEALTH MAINTENANCE ORGANIZATIONS AND FORMS ARE SUBJECT TO THE SAME REQUIREMENTS AS FOR INSURERS GENERALLY; AMENDING SECTIONS 33-1-501 AND 33-31-301, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE AND AN APPLICABILITY DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-1-501, MCA, is amended to read:

"33-1-501. Filing ~~and approval~~ of forms -- approval -- review of disapproval or withdrawal of approval -- application. (1) (a) An insurance policy or annuity contract form, certificate, enrollment form, application form, ~~viatical disclosure form,~~ printed rider or endorsement form, or form of renewal certificate may not be delivered or issued for delivery in Montana unless the form and, for the purposes of disability insurance, an outline of coverage as required by 33-22-244 and 33-22-521 have been filed with and approved by the commissioner and, if required, the regulatory official of the state of domicile of the insurer. This provision does not apply to surety bonds or policies, riders, endorsements, or forms of unique character designed for and used with relation to insurance upon a particular subject or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder. Forms for use in property, marine, other than ocean marine and foreign trade coverages, casualty, and surety insurance coverages may be filed by a rating organization on behalf of its members and subscribers or by a member or subscriber on its own behalf.

(b) A filing required by subsection (1)(a) must be submitted by an officer of the insurer with a certification in a form prescribed by the commissioner. The certification must state that to the best of the officer's knowledge

and belief, the policy, contract form, certificate, enrollment form, application form, ~~viatical disclosure form,~~ printed rider or endorsement form, or form of renewal certificate complies with the applicable provisions of Title 33.

~~(b)~~(c) The approval of an insurance policy or annuity contract form, certificate, enrollment form, application form, or other related insurance form by the state of domicile may be waived by the commissioner if the commissioner considers the requirements of subsection (1)(a) unnecessary for the protection of Montana insurance consumers. If the requirement is waived, an insurer shall notify the commissioner in writing within 10 days of disapproval, denial, or withdrawal of approval of a form by the state of domicile.

(2) (a) The filing must be made not less than 60 days ~~in advance of~~ before delivery and must be delivered by hand or sent by certified mail with a return receipt requested. The commissioner's office shall mark a filing with the date of receipt by the commissioner's office.

(b) (I) If after 60 days from the date of receipt by the commissioner's office the commissioner has not approved or disapproved the form by a notice pursuant to the provisions in subsection (4), the form is considered approved for all purposes, SUBJECT TO SUBSECTION (2)(C).

(II) THE RUNNING OF THE 60-DAY PERIOD IS TOLLED FOR A PERIOD COMMENCING ON THE DATE THAT THE COMMISSIONER NOTIFIES THE INSURER OF PROBLEMS OR QUESTIONS AND REQUESTS ADDITIONAL INFORMATION FROM THE INSURER CONCERNING A FORM FILED PURSUANT TO SUBSECTION (1)(A) AND ENDING ON THE DATE THAT THE INSURER SUBMITS ITS RESPONSE TO THE COMMISSIONER.

(III) FOR PURPOSES OF TOLLING THE 60-DAY PERIOD AS PROVIDED IN SUBSECTION (2)(B)(II), THE COMMISSIONER'S REQUEST NOTIFICATION MAY BE MADE ELECTRONICALLY.

(c) In a letter separate from the original filing and delivered by hand or sent by certified mail with return receipt requested, the insurer shall notify the commissioner, at least 10 days before the use of the form in the market, that the insurer believes that:

(i) the form has been or will be considered approved; and

(ii) the insurer will begin marketing the form in Montana.

(d) The commissioner's office shall mark a letter received pursuant to subsection (2)(c) with the date of receipt by the commissioner's office.

(3) Approval of a form by the commissioner constitutes a waiver of any unexpired portion of the waiting period. ~~The commissioner may extend by not more than an additional 60 days the period within which the commissioner may approve or disapprove a form by giving notice of the extension before expiration of the initial 60-day period.~~

(4) The commissioner may at any time, after notice and for cause shown, withdraw any approval.

~~(3)~~ Notice by the commissioner disapproving a form or withdrawing a previous approval must state the grounds for disapproval or withdrawal in sufficient detail to inform the insurer of the specific reason or reasons for and the legal authority supporting the disapproval or withdrawal of approval in whole or in part. The disapproval or withdrawal of approval does not take effect unless it is issued after the commissioner has reviewed the form and provided notice to the person who filed the form pursuant to 33-1-314 and this subsection.

(5) After the date of the insurer's receipt of notice of disapproval or withdrawal of approval by the commissioner, the insurer may not deliver the form or issue the form for delivery in Montana.

~~(6) The commissioner shall grant a hearing for unresolved disputes regarding a disapproval or a withdrawal of approval within 45 days after receipt of a written request by the person who filed the form.~~

(6) THE INSURER MAY REQUEST A HEARING, AS PROVIDED FOR IN 33-1-701, FOR UNRESOLVED DISPUTES REGARDING A DISAPPROVAL OR A WITHDRAWAL OF APPROVAL.

~~(4)~~(7) The commissioner may exempt from the requirements of this section, for so long as the commissioner considers proper, an insurance document, form, or type of document or form to which, in the commissioner's opinion, this section may not practicably be applied or the filing and approval of which are not desirable or necessary for the protection of the public.

~~(5)~~(8) This section applies to a form used by a domestic insurer for delivery in a jurisdiction outside Montana if the insurance supervisory official of the jurisdiction informs the commissioner that the form is not subject to approval or disapproval by the official and upon the commissioner's order requiring the form to be submitted to the commissioner for the purpose. The same standards apply to these forms as apply to forms for domestic use.

~~(6)~~(9) ~~This section and~~ Section 33-1-502 and this section do not apply to:

(a) reinsurance;

(b) policies or contracts not issued for delivery in Montana or delivered in Montana, except as provided in subsection ~~(5)~~ (8);

(c) ocean marine and foreign trade insurances.

~~(7)~~(10) Except as provided in chapter 21, group certificates that are delivered or issued for delivery in Montana for group insurance policies effectuated and delivered outside Montana but covering persons resident in Montana must be filed with the commissioner upon request. The certificates must meet the minimum provisions mandated by Montana if Montana law prevails over conflicting provisions of other state law."

Section 2. Section 33-31-301, MCA, is amended to read:

"33-31-301. (Temporary) Evidence of coverage -- schedule of charges for health care services. (1) Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner in accordance with 33-1-501.

(3) An evidence of coverage issued or delivered to a person residing in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions,

limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area.

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;

(e) except as provided in 33-22-262, a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or the enrollee's dependents;

(f) a provision providing coverage as required in 33-22-133;

(g) except as provided in 33-22-262, a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for treatment and referral services, the enrollee's designated provider shall limit treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;

(iv) the provisions of this subsection (3)(g) do not apply to services for mental illness provided under the Montana medicaid program as established in Title 53, chapter 6;

(h) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is amended to conform to the minimum requirements of those statutes."

(i) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee, dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of membership in the class or classes eligible for coverage under the policy or because the employer discontinues the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

(j) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner in accordance with 33-1-501 and issued to the enrollee.

(5) (a) Except as provided in 33-22-262, a health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) Except as provided in 33-22-262, a health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) ~~The commissioner shall, within 60 days, approve a form if the requirements of subsections (1) through (5) are met. A health maintenance organization may not issue a form before the commissioner approves the form. If the commissioner disapproves the filing, the commissioner shall notify the filer. In the notice, the commissioner shall specify the reasons for the disapproval. The commissioner shall grant a hearing within 30 days after receipt of a written request by the filer~~ The provisions of 33-1-501 govern the filing and approval of health maintenance organization forms.

(7) The commissioner may require a health maintenance organization to submit any relevant information considered necessary in determining whether to approve or disapprove a filing made pursuant to this section. (Terminates June 30, 2009--sec. 14, Ch. 325, L. 2003.)

33-31-301. (Effective July 1, 2009) Evidence of coverage -- schedule of charges for health care services. (1) Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner in accordance with 33-1-501.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be

obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area.

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;

(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or the enrollee's dependents;

(f) a provision providing coverage as required in 33-22-133;

(g) a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services

for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for treatment and referral services, the enrollee's designated provider shall limit treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;

(iv) the provisions of this subsection (3)(g) do not apply to services for mental illness provided under the Montana medicaid program as established in Title 53, chapter 6;

(h) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is amended to conform to the minimum requirements of those statutes."

(i) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee, dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of membership in the class or classes eligible for coverage under the policy or because the employer discontinues the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

(j) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in

a separate document if the separate document is filed with and approved by the commissioner in accordance with 33-1-501 and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) ~~The commissioner shall, within 60 days, approve a form if the requirements of subsections (1) through (5) are met. A health maintenance organization may not issue a form before the commissioner approves the form. If the commissioner disapproves the filing, the commissioner shall notify the filer. In the notice, the commissioner shall specify the reasons for the disapproval. The commissioner shall grant a hearing within 30 days after receipt of a written request by the filer~~ The provisions of 33-1-501 govern the filing and approval of health maintenance organization forms.

(7) The commissioner may require a health maintenance organization to submit any relevant information considered necessary in determining whether to approve or disapprove a filing made pursuant to this section."

NEW SECTION. **SECTION 3. EFFECTIVE DATE.** [THIS ACT] IS EFFECTIVE JANUARY 1, 2006.

NEW SECTION. **Section 4. Applicability.** [This act] applies to all policies, forms, and certificates filed with the commissioner of insurance ON OR after [the effective date of this act].

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